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	344004	A. BUILDING _____ B. WING _____	C 03/10/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN UMSTEAD HOSP	1003 12TH ST BUTNER, NC 27509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 006	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: An unannounced visit was made to the hospital on March 4 and 10, 2005 to investigate a patient death in the hospital's Admissions unit ward 234. Based on staff interview, medical record review, hospital documents, observations and review of hospital policies and procedures, the hospital's governing body failed to ensure that: A) patient's were free from neglect and received care in a safe setting, B) Conditions of Participation were met, and C) staff implemented patient supervision policies and procedures. Immediate Jeopardy was cited due to the lack of patient safety, as: A) patients were not supervised by staff in accordance with hospital policy, The cumulative effect of these systemic problems resulted in the hospital's inability to ensure patients received care in a safe environment. A) Cross refer: Tag A0016 Governing Body, CFR 482.12(c). The governing body failed to ensure proper patient care as required by the hospital's policies and procedures.	A 006		
A 016	482.12(c) CARE OF PATIENT	A 016		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 016	Continued From page 1 In accordance with hospital policy, the governing body must ensure that specific patient care requirements are met. This STANDARD is not met as evidenced by: Based on staff interview, medical record review, observations, and review of hospital policies and procedures, the hospital's governing body failed to ensure hospital policies and procedures were implemented and specific patient care needs were met in the hospital's Admissions unit ward 234. A) Cross refer: Tag A0204 Staffing and Delivery of Care, CFR 482.23(b)(3). Nursing staff failed to monitor patients in accordance with hospital policies and procedures. B) Cross refer: Tag A 057 Privacy and Safety--482.13(c)(2). The hospital staff failed to ensure patients received care in a safe setting. C) Cross refer: Tag A058 Privacy and Safety--482.13(c)(3). The hospital staff failed to ensure patients were free from all forms of abuse including neglect.	A 016		
A 038	482.13 PATIENTS' RIGHTS A hospital must protect and promote the rights of each patient. This CONDITION is not met as evidenced by: Based on medical record review, policies and procedures review, hospital document review and staff interviews, the hospital failed to protect and	A 038		

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A 038	Continued From page 2 promote each patient's right to be free from neglect, and be provided with staff supervision to prevent a patient from self-injurious behavior. Specifically, staff did not provide supervision on the Admissions unit ward 234 in accordance with hospital policy and procedure. Immediate Jeopardy was cited due to the lack of patient safety. --Cross refer: Tag A 057 Privacy and Safety--482.13(c)(2) The hospital failed to ensure 12 of 12 patients received care in a safe setting (patients #1-#12) on the Admissions unit by failing to ensure staff followed hospital policy regarding supervision of patients. --Cross refer: Tag A058 Privacy and Safety--482.13(c)(3) The hospital failed to ensure one of one patient (patient #1) was free from all forms of abuse including neglect by failing to provide services necessary to prevent physical harm to patient #1.	A 038		
A 057	482.13(c)(2) RECEIVE CARE IN A SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on medical record review, staff interviews, review of policy and procedures, review of hospital documents, and observations, the hospital failed to provide supervision to ensure the safety for 12 of 12 patients (#1-#12) reviewed. Findings include:	A 057		

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A 057	Continued From page 3 1) Medical record review conducted on 3-4-05 revealed Patient #1, a 22-year old male, was admitted to the Adult Admissions Unit (Ward 234) on 2-21-05 with the diagnosis of Schizophrenia - Undifferentiated. Review of the "Certificate of Death" in the medical record revealed Patient #1 died on 3-3-05 and the immediate cause of death was "suicide". On 3-10-05 the "Adult Admissions Unit Ward Assignments" document, dated 3-3-05, was reviewed. The document confirmed that Staff #1 (a Health Care Technician who worked second shift on ward 234 on 3-3-05) was responsible for the 30 minute patient checks from 5:00pm until 7:00pm. Further review of Patient #1's medical record revealed the "Adult Admissions Unit Patient Check Sheet", dated 3-3-05. The " Patient Check Sheet" listed patient names (each patient for Ward 234), room number, restrictions (ie Escape, Assault, Suicide) and the location (using an abbreviated code) of each patient documented in 30 minute increments (ie 3:00pm, 3:30pm, 4:00pm, etc.) Further review of the "Patient Check Sheet" revealed Patient #1 was in his room (abbreviated Rm) at 5:00pm. The documentation in the 5:30pm and 6:00pm time slots was illegible for Patient #1 (The documentation for 5:30pm and 6:00pm was marked through). An interview was conducted on 3-4-05 with the Health Care Technician (Staff #1) who was responsible for the "Patient Check Sheet" from 5:00pm until 7:00pm on 3-3-05. Staff #1 reported that the 5:30pm box on the "Patient Check Sheet"	A 057		

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A 057	Continued From page 4	A 057		

stated "refused", which meant "the patient did not show up for his tray" (dinner tray). For the 6:00pm box on the "Patient Check Sheet", Staff #1 stated "I didn't know what to put there." Staff #1 reported he called out Patient #1's name at 5:30pm to get his meal tray and "didn't see the patient (Patient #1) at 5:30pm". Staff #1 stated "I finished giving out trays. I went to get another patient out of his room because he's diabetic and then he started acting out. I got that other resident settled and then went to get (Patient #1's name) around 5:45/5:48pm". Interview revealed Staff #1 went back to the desk (nurses' station) and informed Staff #2 (charge nurse on ward 234 during second shift on 3-3-05) that he could not find Patient #1. Staff #1 and #2 went searching and found Patient #1 hanging in the shower.

The hospital policy entitled "Accounting for Patients" was reviewed on 3-4-05. The policy stated "...It is the responsibility of nursing personnel assigned direct patient care to account for patient movement." The policy further stated "...Rounds should involve visual contact with the patient...". There was no evidence on the "Patient Check Sheet"or in interview with Staff #1 that visual contact was made with Patient #1 at 5:30pm on 3-3-05.

The personnel file for Staff #1 was reviewed on 3-10-05. Review of Staff #1's file revealed he completed the AAU (Adult Admissions Unit) Assessment Checklist on 1-5-05. The AAU Assessment Checklist indicated that Staff #1 had been trained to maintain the safety of the milieu and document the delivery of care per nursing documentation policy.

2) Observations were made on 3-10-05 on Ward

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234. The surveyor arrived to Ward 234 at 3:55pm and requested to make 30 minute patient checks at 4:00pm with the responsible Health Care Technician (Staff #4). Staff #4 approached surveyor and provided the "Patient Check Sheet", dated 3-10-05. At 3:55pm the "Patient Check Sheet" already contained documentation for the 4:00pm and 4:30pm time slots.

Interview with Staff #4 on 3-10-05 revealed "this was an accident" (it was an accident that the 4:00pm and 4:30pm times slots had been pre-documented). Staff #4 further reported that two groups were being held from 3:30-4:30pm: the Foundations Group that is held on the ward (ward 234) and the Fitness Group that takes place off the ward. Staff #4 provided a list of 11 patients, dated 3-10-05, that were scheduled to participate in the Foundations Group on Ward 234. Review of this patient list revealed that the 30 minute checks were pre-documented for the 4:00pm and 4:30pm time slots for all patients on the ward (those who were on the ward in the Foundations Group and those who were off the ward in the Fitness Group). By pre-documenting the "Patient Check Sheet", the hospital failed to provide accountability for each patient on Ward #234 as outlined in the hospital policy "Accounting for Patients". Failure to follow this policy jeopardized the safety of each patient on Ward #234, the same ward where actual harm had occurred to Patient #1 on 3-3-05.

The personnel file was reviewed on 3-10-05 for Staff #4. Review of Staff #4's file revealed he completed the AAU Assessment Checklist on 1-7-05. The AAU Assessment Checklist indicated that Staff #4 had been trained to maintain the safety of the milieu and document

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A 057	Continued From page 6 the delivery of care per nursing documentation policy. Hospital staff failed to provide supervision for patients on ward 234 on 3-10-05 and failed to supervise and make visual contact with Patient #1 on 3-3-05 at 5:30pm in accordance with the hospital's policy and procedure entitled "Accounting for Patients". Administrative staff interview on 3-10-05 confirmed Staff #1 and Staff #4 on ward 234 did not follow the hospital's policy and procedure entitled "Accounting for Patients".	A 057		
A 058	482.13(c)(3) FREE FROM ABUSE & HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on medical record review, staff interviews, policy and procedures review, and hospital document review, the hospital failed to ensure one of one patient (patient #1) was free from neglect by failing to provide services necessary to prevent physical harm to patient #1. Findings include: An unannounced death investigation was conducted on ward 234 of the Admissions Unit of the hospital on March 4 and March 10, 2005. Medical record review conducted on 3-4-05 revealed Patient #1, a 22-year old male, was admitted to the Adult Admissions Unit (Ward 234) on 2-21-05 with the diagnosis of Schizophrenia -	A 058		

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A 058	Continued From page 7	A 058		

Undifferentiated. Review of the "Certificate of Death" in the medical record revealed Patient #1 died on 3-3-05 and the immediate cause of death was "suicide".

Review of Patient #1's medical record revealed a Psychiatric Assessment, completed by the physician and dated 2-21-05, which stated "...He endorses auditory hallucinations over the last two years, feels they have been worse recently, but is unsure how long. He states he does not understand what the voices say, denies command auditory hallucinations, but did get a knife the day prior to admission with plans to kill himself...". The Psychiatric Assessment also revealed Patient #1 "...currently denies suicidal or homicidal ideations...".

Further review of Patient #1's medical record revealed the physician's orders, dated 2-21-05 (the day of admission) at 10:30am, in which Patient #1 was placed on Assault Precautions. According to a physician's progress note, dated 2-21-05 at 2:00pm, Patient #1 was placed on AP (Assault Precautions) because "staff feel pt. seems angry". Further review of the physician's orders revealed an order, dated 3-2-05 at 6:00pm, which stated "D/C AP-to start tonight". Further review of the physician's orders revealed Patient #1 was placed on "Escape Precautions" on 2-28-05 at 4:45pm. According to the physician's progress note, dated 2-28-05 at 5:45pm, Patient #1 was placed on EP (Escape Precautions) for "showing signs of trying to escape". There was no evidence in the medical record that revealed Patient #1 was placed on suicide precautions.

An interview was conducted with Patient #1's

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A 058	Continued From page 8	A 058		

physician on 3-10-05. The physician reported that Patient #1's main complaint upon admission was auditory hallucinations (AH), but Patient #1 denied command AH. The physician stated that Patient #1 "never expressed SI (suicidal ideation) to me" and that he "seemed to be steadily improving". The physician reported that the day before the suicide (3-2-04) Patient #1's auditory hallucinations were improving and that no SI was voiced by Patient #1 at that time.

Review of Patient #1's medical record revealed a LPN (Staff #3) progress note, dated 3-3-05 at 5:15pm, which stated "Client given Ativan 1mg po (by mouth) and Haldol 5mg for agitation at 4:20pm. Client in bed asleep at this time". Review of the Medication Administration Record (MAR) confirmed Patient #1 received Ativan and Haldol at 4:20pm.

A telephone interview was conducted with Staff #3 on 3-14-04 at 3:33pm. Staff #3 reported he usually works on Ward 238, but worked on Ward 234 on the second shift of 3-3-04. Staff #3 reported Patient #1 requested PRN (as needed) medication because "He told me he was agitated". Staff #3 confirmed he gave Patient #1 the medications at 4:20pm (on 3-3-05). Staff #3 reported that Patient #1 asked if he could go to his room (around 4:30pm). Staff #3 stated he unlocked Patient #1's room for him (patient rooms are usually locked between 3:30-4:30pm for groups). Staff #3 reported he was getting ready to go to his supervisor's office , but checked on Patient #1 prior to leaving the ward around "5:10-5:15pm, I think it was 5:15". Staff #3 stated "I walked in the room and the patient was lying in bed asleep on his left side". Staff #3 reported he did not tell anyone that he saw Patient #1 at

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5:10-5:15pm prior to leaving the ward.

Additional review of Patient #1's medical record revealed a progress note, dated 3-3-05 at 5:50pm, in which a Health Care Technician (Staff #1) documented "...At 5:48 I approached pt (patient) room and did not see him. Approached nurses' desk, report did not see him. Writer an RN (Registered Nurse) went back to room and found him in bathroom shower with a brown leather belt tied around neck and tie to rail. Pt. crouch down in shower. Unloosen belt while Rn call code. Pull pt out of shower and got red bag and AAD (automatic defibrillator)". Further review of the progress notes revealed documentation by a Registered Nurse (Staff #2), dated 3-3-05 at 6:00pm, which stated "HCT (Staff #1) notified me that pt. had not eaten supper. Initial search by HCT for pt's was unsuccessful...Writer went with HCT to pt's room and found pt. in shower stall of his room. Pt. unresponsive and grey at lips with belt buckled tightly around his neck..." Further review of the progress notes revealed documentation by a physician, dated 3-3-05 at 6:25pm through 6:32pm. The physician documented "Responded to Code Blue, found (physician's name) and (physician's name) on site responding, CPR being performed, pt unresponsive, pupils dilated, fixed. CPR unsuccessful, pt pronounced dead at 6:23pm

On 3-10-05 the "Adult Admissions Unit Ward Assignments" document, dated 3-3-05, was reviewed. The document confirmed that Staff #1 was responsible for the 30 minute patient checks from 5:00pm until 7:00pm.

Further review of Patient #1's medical record revealed the "Adult Admissions Unit Patient

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Check Sheet", dated 3-3-05. The " Patient Check Sheet" listed patient names (each patient for Ward 234), room number, restrictions (ie Escape, Assault, Suicide) and the location (using an abbreviated code) of each patient documented in 30 minute increments (ie 3:00pm, 3:30pm, 4:00pm, etc.) Further review of the "Patient Check Sheet" revealed Patient #1 was in his room (abbreviated Rm) at 5:00pm. The documentation in the 5:30pm and 6:00pm time slots was illegible for Patient #1 (The documentation for 5:30pm and 6:00pm was marked through).

An interview was conducted on 3-4-05 with the Health Care Technician (Staff #1) who was responsible for the "Patient Check Sheet" from 5:00pm until 7:00pm on 3-3-05. Staff #1 reported that the 5:30pm box on the "Patient Check Sheet" stated "refused", which meant "the patient did not show up for his tray" (dinner tray). For the 6:00pm box on the "Patient Check Sheet", Staff #1 stated "I didn't know what to put there." Staff #1 reported he called out Patient #1's name at 5:30pm to get his meal tray and "didn't see the patient (Patient #1) at 5:30pm". Staff #1 stated "I finished giving out trays. I went to get another patient out of his room because he's diabetic and then he started acting out. I got that other resident settled and then went to get (Patient #1's name) around 5:45/5:48pm". Interview revealed Staff #1 went back to the desk (nurses' station) and informed Staff #2 that he could not find Patient #1. Staff #1 and #2 went searching and found Patient #1 hanging in the shower.

Staff #1 also stated "I really didn't see or work with him (Patient #1) much yesterday (3-3-05). I wasn't assigned to him but when the trays came I

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thought I would get him like I always do. I had worked with him (Patient #1) all weekend . He stayed to himself and I got a positive response with him if I gave him encouragement".

An interview was conducted on 3-4-05 with Staff #2, who was charge nurse on Ward 234 during second shift on 3-3-05. Staff #2 stated "I didn't have a lot of contact with the patient", but reported Patient #1 was a little more "present" (more verbal and more eye contact per Staff #2) in the conversation with Staff #1.

On 3-4-05, statements written by Staff #1 and #2 regarding the suicide of Patient #1 were reviewed. Staff #1 and #2 signed and dated their respective statements on 3-4-05 stating that the information was correct. Staff #1 and #2 had written the statements on the hospital document entitled "Adverse/Sentinel Event Management/Investigation Statement" as part of the hospital's internal investigation.

The hospital policy entitled "Accounting for Patients" was reviewed on 3-4-05. The policy stated "...It is the responsibility of nursing personnel assigned direct patient care to account for patient movement" and "Assigned staff are expected to perform rounds at least every thirty minutes...". The policy further stated "...Rounds should involve visual contact with the patient...". There was no evidence on the "Patient Check Sheet" or in interview with Staff #1 that visual contact was made with Patient #1 on 3-3-05 at 5:30pm.

The personnel file were reviewed on 3-10-05 for Staff #1. Review of Staff #1's file revealed he completed the AAU (Adult Admissions Unit)

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A 058	Continued From page 12 Assessment Checklist on 1-5-05. The AAU Assessment Checklist indicated that Staff #1 had been trained to maintain the safety of the milieu and document the delivery of care per nursing documentation policy. Staff neglected to provide care and services to protect patient #1 from self-injurious behavior. The hospital staff failed to provide supervision and make visual contact with patient #1 on 3-3-05 at 5:30pm in accordance with the hospital's policy entitled "Accounting for Patients". Administrative staff interview on 3-10-05 confirmed Staff #1 on ward 234 did not follow the hospital's policy and procedure entitled "Accounting for Patients" on 3-3-05 at 5:30pm.	A 058		
A 199	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on staff interview, medical record review, and hospital document review, and observations the hospital's Admissions unit nursing management neglected to have effective systems in place to assure the safety of patients and to ensure that patient needs were met; specifically, nursing staff did not monitor patients for safety in accordance with hospital policy. Immediate Jeopardy was cited due to the lack of patient safety.	A 199		

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	344004	A. BUILDING _____ B. WING _____	C 03/10/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHN UMSTEAD HOSP	1003 12TH ST BUTNER, NC 27509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 199	Continued From page 13 Cross refer: Tag A0204 Staffing and Delivery of Care, CFR 482.23(b)(3). Nursing staff failed to monitor patients in accordance with hospital policies and procedures.	A 199		
A 204	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on staff interview, medical record reviews, and policies and procedures review, nursing staff failed to ensure that a registered nurse supervised and evaluated nursing care; specifically, nursing staff failed to supervise and monitor patients in accordance with safety and supervision policy and procedures for 12 of 12 sampled patients. Immediate Jeopardy was cited due to the lack of patient safety. Findings include: 1) Medical record review conducted on 3-4-05 revealed Patient #1, a 22-year old male, was admitted to the Adult Admissions Unit (Ward 234) on 2-21-05 with the diagnosis of Schizophrenia - Undifferentiated. Review of the "Certificate of Death" in the medical record revealed Patient #1 died on 3-3-05 and the immediate cause of death was "suicide". On 3-10-05 the "Adult Admissions Unit Ward Assignments" document, dated 3-3-05, was reviewed. The document confirmed that Staff #1	A 204		

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A 204	Continued From page 14 (a Health Care Technician who worked second shift on ward 234 on 3-3-05) was responsible for the 30 minute patient checks from 5:00pm until 7:00pm. Further review of Patient #1's medical record revealed the "Adult Admissions Unit Patient Check Sheet", dated 3-3-05. The " Patient Check Sheet" listed patient names (each patient for Ward 234), room number, restrictions (ie Escape, Assault, Suicide) and the location (using an abbreviated code) of each patient documented in 30 minute increments (ie 3:00pm, 3:30pm, 4:00pm, etc.) Further review of the "Patient Check Sheet" revealed Patient #1 was in his room (abbreviated Rm) at 5:00pm. The documentation in the 5:30pm and 6:00pm time slots was illegible for Patient #1 (The documentation for 5:30pm and 6:00pm was marked through). An interview was conducted on 3-4-05 with the Health Care Technician (Staff #1) who was responsible for the "Patient Check Sheet" from 5:00pm until 7:00pm on 3-3-05. Staff #1 reported that the 5:30pm box on the "Patient Check Sheet" stated "refused", which meant "the patient did not show up for his tray" (dinner tray). For the 6:00pm box on the "Patient Check Sheet", Staff #1 stated "I didn't know what to put there." Staff #1 reported he called out Patient #1's name at 5:30pm to get his meal tray and "didn't see the patient (Patient #1) at 5:30pm". Staff #1 stated "I finished giving out trays. I went to get another patient out of his room because he's diabetic and then he started acting out. I got that other resident settled and then went to get (Patient #1's name) around 5:45/5:48pm". Interview revealed Staff #1 went back to the desk (nurses' station)	A 204		

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A 204	Continued From page 15	A 204		

and informed Staff #2 (charge nurse on ward 234 during second shift on 3-3-05) that he could not find Patient #1. Staff #1 and #2 went searching and found Patient #1 hanging in the shower.

The hospital policy entitled "Accounting for Patients" was reviewed on 3-4-05. The policy stated "...It is the responsibility of nursing personnel assigned direct patient care to account for patient movement." The policy further stated "...Rounds should involve visual contact with the patient...". There was no evidence on the "Patient Check Sheet"or in interview with Staff #1 that visual contact was made with Patient #1 at 5:30pm on 3-3-05.

The personnel file for Staff #1 was reviewed on 3-10-05. Review of Staff #1's file revealed he completed the AAU (Adult Admissions Unit) Assessment Checklist on 1-5-05. The AAU Assessment Checklist indicated that Staff #1 had been trained to maintain the safety of the milieu and document the delivery of care per nursing documentation policy.

2) Observations were made on 3-10-05 on Ward 234. The surveyor arrived to Ward 234 at 3:55pm and requested to make 30 minute patient checks at 4:00pm with the responsible Health Care Technician (Staff #4). Staff #4 approached surveyor and provided the "Patient Check Sheet", dated 3-10-05. At 3:55pm the "Patient Check Sheet" already contained documentation for the 4:00pm and 4:30pm time slots.

Interview with Staff #4 on 3-10-05 revealed "this was an accident" (it was an accident that the 4:00pm and 4:30pm times slots had been pre-documented). Staff #4 further reported that

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A 204	Continued From page 16	A 204		

two groups were being held from 3:30-4:30pm: the Foundations Group that is held on the ward (ward 234) and the Fitness Group that takes place off the ward. Staff #4 provided a list of 11 patients, dated 3-10-05, that were scheduled to participate in the Foundations Group on Ward 234. Review of this patient list revealed that the 30 minute checks were pre-documented for the 4:00pm and 4:30pm time slots for all patients on the ward (those who were on the ward in the Foundations Group and those who were off the ward in the Fitness Group). By pre-documenting the "Patient Check Sheet", the hospital failed to provide accountability for each patient on Ward #234 as outlined in the hospital policy "Accounting for Patients". Failure to follow this policy jeopardized the safety of each patient on Ward #234, the same ward where actual harm had occurred to Patient #1 on 3-3-05.

The personnel file was reviewed on 3-10-05 for Staff #4. Review of Staff #4's file revealed he completed the AAU Assessment Checklist on 1-7-05. The AAU Assessment Checklist indicated that Staff #4 had been trained to maintain the safety of the milieu and document the delivery of care per nursing documentation policy.

Hospital staff failed to provide supervision for patients on ward 234 on 3-10-05 and failed to supervise and make visual contact with Patient #1 on 3-3-05 at 5:30pm in accordance with the hospital's policy and procedure entitled "Accounting for Patients".

Administrative staff interview on 3-10-05 confirmed Staff #1 and Staff #4 on ward 234 did not follow the hospital's policy and procedure

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A 204	Continued From page 17 entitled "Accounting for Patients".	A 204		